Second Look Commission
2012 Annual Report

Tennessee Commission on Children and Youth

601 Mainstream Drive

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Introduction

The Second Look Commission (SLC) was created in 2010 by Public Chapter 1060 (codified as TCA §37-3-801 *et seq.*) as a unique entity with a single purpose: to make findings and recommendations regarding whether severe abuse cases are handled in a manner that provides adequate protection for the children of Tennessee. The SLC is the only entity that brings together representatives of all key stakeholders in the child protection system in Tennessee: members of the General Assembly, Department of Children's Services (DCS), law enforcement (including the Tennessee Bureau of Investigation and officers from urban and rural areas), district attorneys general, public defenders, courts, child advocacy centers, a physician who specializes in child abuse detection, and other children's advocates. The SLC is the only entity with statutory authority to hold closed meetings to critically analyze confidential information in individual cases, and also to compel participants in the investigation and disposition of the cases reviewed to appear before it to discuss issues and answer questions. The SLC is the vehicle for representatives of these key groups to meet together to review cases and identify strategies for improving child protection in Tennessee.

The SLC reviews some of the worst incidents of child abuse and neglect in Tennessee. Only the Second Look Commission reviews cases of children from all across Tennessee who have experienced a second or subsequent incidence of severe abuse to identify ways to improve the system and help other children avoid a similar fate. Special, concentrated efforts must also be devoted to analyzing and responding to the tragedy of child abuse. The SLC was created as a catalyst to facilitate improved response to child abuse. The composition of the SLC includes representatives of all key stakeholders and disciplines and members of the General Assembly, and it has facilitated much needed communication and collaboration.

Many departments, agencies, entities and community members are involved in a wide range of efforts to protect Tennessee's children from child abuse and neglect and properly respond to such abuse when it occurs. In various degrees and manners, all these child advocates collaborate to provide better protection for our children. Despite their ongoing efforts, Tennessee's children are still traumatized by the horrific experiences of repeated incidents of severe child abuse. The issues regarding severe child abuse cannot be adequately addressed by DCS, TCCY, Child Advocacy Centers, law enforcement or any one organization, or community agency or individual. All stakeholders must come together to address this societal problem in a coordinated and concerted manner. The 1980s brought a dramatic increase in acknowledgement of child sexual abuse and a growing awareness that child protective services, law enforcement, and the criminal justice system were not working together in response to child abuse allegations. In 1985, the Tennessee General Assembly recognized the complex nature of these cases and enacted legislation that established Child Protective Investigative Teams (CPIT). CPITs across the state are composed of professionals who bring a diversity of skills, backgrounds and training

to the investigation. Team members include representatives of child protective services, law enforcement, child advocacy center staff, district attorneys, mental health and juvenile court. In 1990, Children's Advocacy Centers (CACs) developed in Tennessee as child-focused, facility-based programs where representatives from CPITs work together to conduct investigations and make team decisions regarding severe abuse cases.

As a result of these reforms, most sexually and severely abused children are interviewed in child-friendly environments by professionals skilled in conducting these interviews. The investigation and prosecution of these cases has also improved tremendously in recent decades. Despite these and other reforms, more remains to be done. It is our hope that the proposed recommendations of the SLC will be embraced and implemented and will spur child protection professionals to engage in meaningful dialogue that will produce additional ideas for reducing repeat abuse of our children.

Impact of Child Abuse

The future prosperity of any society depends on its ability to foster the health and well-being of the next generation. When a society invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

The basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets build; a strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties. The interactive influences of genes and experience shape the developing brain. The active ingredient is the "serve and return" relationships with their parents and other caregivers in their family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction through babbling and facial expressions. If adults do not respond by getting in sync and doing the same kind of vocalizing and gesturing back at them, the child's learning process is incomplete. This has negative implications for later learning.

Chronic stressful conditions such as extreme poverty, **child abuse** or maternal depression – what scientists now call "toxic stress" – can also disrupt the architecture of the developing brain. This can lead to lifelong difficulties in learning, memory and self-regulation.

Children who experience the trauma of child abuse are more likely to have difficulty developing trusting relationships. They are less likely to be successful in school and more likely to exhibit behavior problems. They are more likely to have mental health and substance abuse treatment needs. Even in adulthood, they are more likely to experience challenges maintaining stable relationships and employment. Too frequently, child abuse is intergenerational, and effective

responses to first instances of abuse are more likely to reduce future abuse not only to that individual child, but to future generations.

Preventing child abuse and intervening effectively when it first occurs are keys to avoiding lifelong negative consequences from child abuse. Cases reviewed by the Second Look Commission make it abundantly clear that there are gaping holes in the systems responding to child maltreatment in Tennessee. As a state, we can and we must identify and implement strategies to ensure children who experience severe abuse, who are among the most vulnerable Tennesseans, receive the protection and remediation assistance they deserve.

Renewed Recommendation to Continue the Second Look Commission

The General Assembly should continue the existence of the Second Look Commission through the Sunset/Sunrise Review Process. The Second Look Commission is a viable and an efficient mechanism to identify weaknesses in how severe child abuse cases are handled in Tennessee and to identify strategies to improve responses to severe child abuse.

Over the last two years, the SLC has demonstrated the ability, willingness and desire to fulfill its statutory obligation. Even more than simply fulfilling its statutory obligations, the SLC has gone above and beyond its statutory obligations in attempting to not just "get it right," but to function with excellence. The governing statute requires the SLC to meet at least quarterly. Since its inception, the SLC has held twelve open meetings and nine investigatory meetings. Each meeting lasts between an hour and six hours. The investigatory meetings usually last longer than the open meetings. Many members of the SLC have devoted numerous hours to working and learning during these meetings. However, the meetings are just a portion of the time and effort put forth by the members of the SLC. Members of the SLC read and review investigatory summaries before coming to the meetings. Several of the SLC members conduct their own research into the matters being investigated and share the information with the SLC during meetings. Several of the SLC members talk to people in their geographic area who were involved in the matter being investigated. DCS is not the only member that regularly contributes to the SLC outside of the meetings. The SLC is a viable Commission.

Not only is the SLC viable, it is also efficient. The SLC is statutorily comprised of seventeen members. The SLC only has one paid position, the director. The director performs a substantial portion of the administrative tasks of the SLC so the members can devote their expertise and limited resources to addressing the more substantive aspects of the SLC's purpose. Moreover, thanks to the support of the Administrative Office of the Courts, the SLC has minimized travel expenses by making videoconferencing available in east and west Tennessee to its members for all of the meetings.

The SLC is a unique entity with a unique purpose: to make recommendations and findings regarding whether severe child abuse cases are handled in a manner that provides adequate protection to the children of Tennessee by investigating cases in which children have been the victim of second or subsequent incidents of abuse. Specialized, collaborative and concentrated efforts must be devoted to analyzing and responding to these tragedies. The SLC provides such efforts with minimal costs and maximum expertise.

It is a critical entity because involvement of all groups represented on the SLC is essential for assuring Tennessee responds effectively to child abuse and neglect. Through its knowledgeable and diverse membership and consultative input from various key stakeholders in preventing child abuse, the SLC continues to identify several weaknesses and opportunities for improvement of how to handle severe child abuse cases as set forth in this report. However, identifying weaknesses and making recommendations are just the beginning of improving how severe child abuse cases are handled. The data and various processes must be tracked and evaluated over time to determine whether recommendations are implemented.

Findings and Recommendations 2012

Based on insights and hard work from its first year of existence, the SLC was able to improve upon its previous efforts. This year the SLC was able to devote more time to examining cases because it did not have to spend a substantial amount of time determining how the cases would be chosen. Additionally, the SLC decided to review fewer cases this year to be able to devote more time on each case reviewed. The SLC continues to improve and continues to identify opportunities to improve the process to obtain better information and data.

During 2012, the SLC thoroughly reviewed a sample of cases of children who experienced second or subsequent incidents of severe child abuse. The review process was often painful as members considered the horrific experiences endured by the children whose cases were reviewed, and through the review process could see missed opportunities that could have prevented repeat abuse. The SLC determined there are significant problems with the manner in which severe child abuse cases are being handled in Tennessee. It will take a concerted and sustained effort to peel away the many layers of this complex issue to get to the core. Additional time and effort are required to competently and adequately address the issues and problems.

The following findings and recommendations are based on the cases reviewed.

1. **Reoccurring Finding**: There is a need to strengthen relationships, interaction and investigation, and to improve communication and collaboration to reduce the incidents and impact of severe child abuse in Tennessee.

Recommendations: Develop improved joint and collaborative training for all child abuse investigation stakeholders based on the identification of opportunities to improve practices.

Monitor and support, when appropriate, the efforts of In Home Tennessee.

Explanation: During the course of investigating cases, the SLC identified several opportunities to improve practices and better protect children. In one incident, a Drug Exposed Child investigation was closed as "Unable to Complete" due to the lack of cooperation by the family. The DCS investigator was not able to contact the family despite the fact that law enforcement was having contact with the family. In a related matter, SLC members questioned the extent to which law enforcement shared information it had regarding allegations of exposing the child to drugs. The SLC noted the deficiencies in the investigation of this matter presented opportunities for training when investigating cases of alleged Drug Exposed Child. Drug Exposed Child cases are often gateways to address other issues within the family that may impact the safety and well-being of the child. Stakeholders working with children and families in Drug Exposed Child cases should be cross-trained to increase stakeholders' awareness of other issues that need to be addressed.

In another incident, DCS received a referral alleging Drug Exposed Child, Environmental Neglect, Physical Abuse, and Psychological Harm. The case was closed as Unable to Complete because the mother and children were allegedly in a domestic violence shelter in an undisclosed location. This matter presents opportunities to improve collaboration and communication so DCS could have verified where the children were and to confirm they were safe. Approximately seven months later, DCS received a referral on the same family alleging Lack of Supervision by the mother. DCS investigated the matter and provided the necessary services and resources to address the Lack of Supervision referral. Nothing in the documentation provided to the SLC indicated DCS investigated the previous referral regarding the Drug Exposed Child, Environmental Neglect, Physical Abuse, and Psychological Harm allegations. This matter presents opportunities for training to address improving the quality of investigations.

Once again, the SLC noted several occasions in which alleged perpetrators refused to cooperate in various manners and no further action was taken to obtain cooperation other than asking the alleged perpetrator to comply with the requests.

The In Home Tennessee initiative appears to address some of the issues identified. Through In Home Tennessee, a training curriculum has been developed to enhance the skills of DCS workers. The Integrating Assessments skill workshop is intended to enable the participants to better assess and evaluate the children and families they serve. The

course is intended to enhance the participants' ability to conduct complete and accurate assessments of the family risks. This course is also intended to address the need for proper supervision by challenging supervisors to think about how they can support their staff to enhance assessment work.

Through the service array process, In Home Tennessee could address additional communication and collaboration issues identified by the SLC. DCS regions have developed the following workgroups and/or actions: Integrated Community Agency Meetings, Knowledge of Resources Workgroup and a Communication Workgroup.

2. **Finding**: There is a need to stress the importance of issue driven investigations as opposed to incident driven investigations through training.

   Recommendation: Multidisciplinary training should be developed to address the need to engage in issue driven investigations. All stakeholders who want to be involved should have an opportunity to help in the development of the training. However, a representative from following agencies or organizations should take the lead in the development of the training: the Department of Children's Services, Child Advocacy Centers, and the Child Protection Investigative Teams.

   Explanation: Cases are being closed and/or investigative and permanency efforts are terminated before proper services are provided because the incident that prompted the investigation was addressed without addressing the underlying issues. Although this issue was not listed as an enumerated finding in the 2011 report, it was identified in last year's report. The SLC recognizes the paramount importance of making sure a child is safe when investigating and otherwise addressing child abuse cases. However, removing a child from a dangerous situation without also addressing the issues which contributed to and created by the abusive incident is not in the best interest of the child. Incident driven investigations produced negative consequences in some of the cases investigated in the 2011 report as well.

   Incident driven investigations can lead to harmful placement disruptions. Without the proper support systems and services for the minor victim and the placement resource, placement disruptions are likely to cause more trauma to the child.

   In a matter investigated by the SLC, the members concluded that, instead of addressing the issues requiring Mary to be placed outside of her mother's home, the matter was resolved by transferring custody of Mary to an out-of-state relative to avoid placing her in state's custody. Moreover, Mary did not receive a proper assessment to determine her needs before the custody transfer occurred. All the parties, including the guardian ad litem, agreed with the decision to transfer custody of the child to the out-of-state relative.

After Mary left the State of Tennessee, she apparently moved from one state to another and was in and out of foster care. Approximately two years later, she found herself back in Tennessee, off her much needed medication, without a home and not in school. A family friend provided a safe and stable place for Mary and obtained emergency custody of Mary.

In another matter investigated by the SLC, Jennifer (a minor mother) and her child Alex were placed in the custody of DCS due to the abandonment of Jennifer. Jennifer was living in a rooming house with Alex's father. Jennifer was not enrolled in school. Two months later, the case was closed and custody of Jennifer was transferred to an adult sibling of Jennifer. Nothing in the documentation provided to the SLC indicates appropriate services were placed in the home of the relative. The relative subsequently asked Jennifer to leave due to Jennifer's unruly behavior. Within one year, the young mother returned to her abusive relationship with Alex's father placing herself and her child in danger.

One of the consultative experts, Jon Ebert, Psy.D., who met with the SLC this year, emphasized the necessity of engaging all the necessary parties, obtaining proper assessments and providing the necessary services in severe child abuse matters. There must be an intentional effort to engage the caregivers in the children's lives and building relationships with foster parents and other individuals. The caregiver's ability to respond to the stress of the child is significant. To properly care for a child, service providers must also work with the parent or caregiver. Working with the parent or caregiver will often include working with the perpetrator, which is essential if reunification is considered. Additionally, the non-offending parent should be assessed to determine what course of action or disposition is in the best interest of the child. The non-offending parent is a significant influence and source of support and protection for the severely abused child. Any caregiver for a severely abused child has an opportunity to help that child in his/her healing process, mentally and physically. They must be given the proper tools to do so.

3. **Finding**: A more consistent best practices model for Child Protective Investigative Teams (CPIT) should be developed and implemented across the state to reduce inconsistent CPIT practices and poor outcomes for children in Tennessee.

   Recommendations: Create a Statewide CPIT Coordinator whose only responsibilities would be assessing and improving the CPIT process throughout Tennessee and monitoring compliance of the various CPITs in Tennessee.

   Develop a CPIT advisory board. At a minimum, the CPIT Advisory Board should include some local CPIT coordinators from across the state.

Explanation: Over thirty years ago, the General Assembly recognized the necessity and potential benefits of the multi-disciplinary approach to investigating child abuse, which is at the core of the CPIT approach. The current statutory scheme regarding the establishment of CPITs and the investigative process used by them provides valuable guidance. Despite the guidance provided by the statutes, additional oversight and direction are needed.

The SLC continues to receive anecdotal information and continues to see evidence that raises concerns regarding the disparity from county to county in the level of involvement of all the key actors within the various CPITs. As stated in the SLC report last year, "Failure to perform with excellence in this process has two predictable and dangerous outcomes: children may be harmed by repeated, sometimes traumatic, interviews; and evidence is less likely to be preserved for future criminal prosecutions."

The creation of a Statewide Child Protective Investigative Team Coordinator position will provide the various CPITs with the support and resources needed to do the best job possible for Tennessee's children and families. Below is a job description for the proposed Statewide Child Protective Investigative Team Coordinator. The suggested job description was developed by a consultative expert who met with the SLC, June Turner, Executive Director of the Nashville Child Advocacy Center.

SUGGESTED JOB DESCRIPTION
STATEWIDE CHILD PROTECTIVE INVESTIGATIVE TEAM COORDINATOR
STATE OF TENNESSEE

- Prepare and issue model protocol/practice guidelines for local multidisciplinary teams regarding the coordination of investigation, prosecution and treatment of severe child abuse
- Review and approve protocol/practice guidelines prepared by local multidisciplinary teams
- Advise local multidisciplinary teams on the investigation and prosecution of severe child abuse
- Receive quarterly data on severe child abuse from statewide CPITs and issue annual reports
- Collect data on the operations of local multidisciplinary teams and seek funding to support special projects relating to the operation of local multidisciplinary teams like specialized training in joint investigations
- Receive and review complaints regarding local multidisciplinary teams and make appropriate recommendations

- Recommend to the General Assembly changes in state programs, legislation, policies, budgets, treatment and service standards which may facilitate effective intervention into severe child abuse cases, the investigation and prosecution of perpetrators of severe child abuse and improve the opportunity for victims of severe child abuse to receive treatment
- Establish and convene a statewide advisory board to resolve senior level policy disputes and issues; establish standards for uniform data collection, standards of practice, and quality assurance; build consensus and solve issues at a state or local level (suggested members of the advisory board – DCS, Police Chiefs' Association, Sheriffs' Association, Tennessee Children's Advocacy Centers, Board Certified Child Maltreatment Pediatrician, Tennessee District Attorney General's Conference)

In addition to the creation of the Statewide Child Protective Investigative Team Coordinator, the SLC recognizes the necessity of statutory consequences for failure to adhere to the statutes governing CPITs. The SLC believes one of the factors contributing to the inconsistency of performance found in the various CPITs is there are not any statutory consequences for failing to comply with the guidelines set forth in the statutes establishing and controlling CPITs. The nature of the consequence and manner of enforcement will likely determine where the CPIT Coordinator position should be located. The SLC will further discuss and develop recommendations regarding where the position should be located.

4. **Finding**: Domestic violence in general and particularly in matters involving children must be properly addressed. The failure to identify and properly address domestic violence issues by severe child abuse prevention stakeholders exposes children to abuse and neglect.

Recommendations: Establish additional family justice centers in Tennessee.

Establish enhanced penalties if the victim of domestic violence is pregnant or if a child is present during the domestic violence. TCA 39-13-111 should be amended to include the following language, "If a minor who is not the alleged perpetrator of the domestic abuse witnesses the domestic assault or the domestic abuse victim is pregnant, the minimum and maximum fines as set forth in TCA 39-13-111(c)(1)-(3) shall be increased by $1,000.00 and the minimum time of confinement shall be increased by 30 days."

Explanation: Domestic violence is a serious problem nationwide. The Centers for Disease Control (CDC) reported each year women experience about 4.8 million intimate partner related physical assaults and rapes and men are the victims of about 2.9 million intimate partner related physical assaults. Even with such alarming rates, the U.S. Department of Justice statistics indicate domestic violence is one of the most chronically underreported crimes. Partner violence can be characterized by one time or on-going

abuse that can ultimately lead to the death of the victim and/or the abuser. The CDC reported partner violence resulted in 2,340 deaths in 2007. Of these deaths, 70 percent were females and 30 percent were males. In addition to the safety concerns for people involved in domestic violence, there are significant financial costs. The medical care, mental health services, and lost productivity (e.g., time away from work) cost of partner violence was an estimated $5.8 billion in 1995. Updated to 2003 dollars, the last available estimate, that is more than $8.3 billion.

Domestic violence has adverse impacts for not only the abused partner, but also for the children witnessing the violence. The prevalence of children witnessing partner violence is clear with 15.5 million U.S. children living in families in which partner violence occurred at least once in the past year, and seven million children live in families where severe partner violence occurred. The adverse impacts on children are extensive and severe. A Michigan study of low-income pre-schoolers found children who have been exposed to family violence suffer symptoms of post-traumatic stress disorder, such as bed-wetting or nightmares, and are at greater risk of having allergies, asthma, gastrointestinal problems, headaches and flu. The CDC also found children who experience childhood trauma, including witnessing domestic violence, are at greater risk of having serious adult health problems. According to the Child Welfare Information Gateway:

> Children who live with domestic violence faced increased risks: the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these may lead to negative outcomes for children and may affect their well-being, safety, and stability (Carlson, 2000; Edleson, 1999; Rossman, 2001). Childhood problems associated with exposure to domestic violence fall into three primary categories:
>
> **Behavioral, social, and emotional problems**. Higher levels of aggression, anger, hostility, oppositional behavior, and disobedience; fear, anxiety, withdrawal, and depression; poor peer, sibling, and social relationships; and low self-esteem.
>
> **Cognitive and attitudinal problems**. Lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem solving skills, pro-violence attitudes, and belief in rigid gender stereotypes and male privilege.
>
> **Long-term problems**. Higher levels of adult depression and trauma symptoms and increased tolerance for and use of violence in adult relationships.

http://www.childwelfare.gov/pubs/factsheets/domesticviolence.cfm

Domestic violence is a Tennessee problem as well. According to information provided during the Tennessee Governor's 2012 Public Safety Forum, "Domestic violence makes up over half of all reported violent crimes in Tennessee year after year." Although it appears reported domestic violence has decreased since 2010, Tennessee was ranked third in the nation for the rate at which women were killed in 2010 by the Violence Policy Center. The Tennessee Economic Council on Women published a report in 2006 outlining the financial costs of domestic violence to the state. It noted domestic violence related cases were costing over $33 million in healthcare costs and $15 million per year for prison costs for domestic violence murderers. They also pointed out the additional cost of placing children in state custody and providing the appropriate services. Domestic violence has significant psychological, physical and financial impacts.

Witnessing violence in the home is a significant risk factor of transmitting violent behavior from one generation to the next. The National Coalition Against Domestic Violence notes, "The consequences of domestic violence can cross generations and truly last a lifetime." It is critical the children and families of Tennessee receive the protections in the law and supports and services they need to be healthy, productive citizens.

One of the Action Steps to Reduce the Level of Domestic Violence identified during the Governor's 2012 Public Safety Forum is to, "Provide more support for domestic violence victim shelters and family safety centers." Goals to support this action step include continued support of existing family justice centers and the state assisting in the creation and implementation of three additional centers in Tennessee.

As evidenced by it's recommendation, the SLC concurs with the supporting of existing family justice centers and creating additional family justice centers. Family justice centers have proven to be a powerful tool used to combat domestic violence. In general, the Family Justice Center model is the co-location of a multi-disciplinary team of professionals who work together to provide coordinated services to victims of family violence. The Family Justice Center approach is based on the San Diego Family Justice Center model. The San Diego Family Justice Center opened in 2002. The San Diego Family Justice Center model has been identified as a best practice in the field of domestic violence intervention and prevention services by the United States Department of Justice. The documented and published outcomes in the Family Justice Center model include: reduced homicides; increased victim safety; increased autonomy and empowerment for victims; reduced fear and anxiety for victims and their children; increased efficiency and coordination among service providers; and reduced recantation and minimization by victims when wrapped in services and support. (See Casey Gwinn, Gael Strack, Hope for

Hurting Families: Creating Family Justice Centers Across America (Volcano Press 2006)).

The suggested increased fines and length of sentence might serve as a deterrent against domestic violence that involves children, human embryos and fetuses as contemplated by T.C.A. 39-13-107. At any rate, the suggested statutory changes increase the time the perpetrator is incarcerated.

5. **Finding**: There is a need to develop and implement a statewide multidisciplinary best practices policy or protocol for all severe child abuse prevention stakeholders to assess and treat children possibly exposed to methamphetamine or refer such children to an appropriate provider.

   Recommendation: The state should provide the necessary support to aid in the development and implementation of a statewide multidisciplinary best practices policy or protocol to be used when dealing with children who may have been exposed to methamphetamine or any stage of producing methamphetamine.

   Explanation: Three of the six cases investigated by the SLC involved methamphetamine. In one case, the SLC noted an unreasonable lapse of time (approximately 40 days) occurred between the dates the child alleged she was exposed to methamphetamine and the medical examination of the child. In the second matter, the SLC questioned if and how the children were treated to address exposure to methamphetamine. DCS did obtain hair follicle tests for the children approximately 2-3 weeks after DCS knew the parents/caregivers tested positive for methamphetamine. The children tested negative. However, the children were tested only one time during the course of the matter. Additionally, the documentation provided to the SLC did not indicate whether the children's clothes or other items were tested. All three matters appeared to have been addressed with varying levels of thoroughness regarding the children's possible exposure to methamphetamine.

   An article published on the U.S. Department of Justice website titled "*Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims,*" (June 2003), clearly sets forth some of the dangers children are exposed to who live at or near methamphetamine laboratories. The portion of the article titled "Dangers to Children Living at Meth Labs" is partially set forth below:

   > A child living at a clandestine methamphetamine laboratory is exposed to immediate dangers and to the ongoing effects of chemical contamination. In addition, the child may be subjected to fires and explosions, abuse and neglect, a hazardous lifestyle (including the presence of firearms), social problems, and other risks.

Chemical contamination. The chemicals used to cook meth and the toxic compounds and byproducts resulting from its manufacture produce toxic fumes, vapors, and spills. A child living at a meth lab may inhale or swallow toxic substances or inhale the secondhand smoke of adults who are using meth; receive an injection or an accidental skin prick from discarded needles or other drug paraphernalia; absorb methamphetamine and other toxic substances through the skin following contact with contaminated surfaces, clothing, or food; or become ill after directly ingesting chemicals or an intermediate product. Exposure to low levels of some meth ingredients may produce headache, nausea, dizziness, and fatigue; exposure to high levels can produce shortness of breath, coughing, chest pain, dizziness, lack of coordination, eye and tissue irritation, chemical burns (to the skin, eyes, mouth, and nose), and death. Corrosive substances may cause injury through inhalation or contact with the skin. Solvents can irritate the skin, mucous membranes, and respiratory tract and affect the central nervous system. Chronic exposure to the chemicals typically used in meth manufacture may cause cancer; damage the brain, liver, kidney, spleen, and immunologic system; and result in birth defects. Normal cleaning will not remove methamphetamine and some of the chemicals used to produce it. They may remain on eating and cooking utensils, floors, countertops, and absorbent materials. Toxic byproducts of meth manufacturing are often improperly disposed outdoors, endangering children and others who live, eat, play, or walk at or near the site.

Fires and explosions. Approximately 15 percent of meth labs are discovered as a result of a fire or explosion. Careless handling and overheating of highly volatile hazardous chemicals and waste and unsafe manufacturing methods cause solvents and other materials to burst into flames or explode. Improperly labeled and incompatible chemicals are often stored together, compounding the likelihood of fire and explosion. Highly combustible materials left on stovetops, near ignition sources, or on surfaces accessible to children can be easily ignited by a single spark or cigarette ember. Hydrogenerators used in illegal drug production "constitute bombs waiting to be ignited by a careless act." Safety equipment is typically nonexistent or inadequate to protect a child.

Abuse and neglect. Children living at methamphetamine laboratories are at increased risk for severe neglect and are more likely to be physically and sexually abused by members of their own family and known individuals at the site. Parents and caregivers who are meth dependent typically become careless, irritable, and violent, often losing their capacity to nurture their children. In these situations, the failure of parents to protect their children's safety and to provide for essential food, dental and medical care (including immunizations, proper hygiene, and grooming), and appropriate sleeping conditions is the norm. Older siblings in these homes often assume the role of caretaker. Some addicted parents fall into a deep sleep for days and cannot be awakened, further increasing the likelihood that their children will be exposed to toxic chemicals in their environment and to abusive acts committed by the other drug-using individuals who are present.

Children living at meth lab sites may experience the added trauma of witnessing violence, being forced to participate in violence, caring for an incapacitated or injured parent or sibling, or watching the police arrest and remove a parent.

Hazardous lifestyle. Hazardous living conditions and filth are common in meth lab homes. Explosives and booby traps (including trip wires, hidden sticks with nails or spikes, and light switches or electrical appliances wired to explosive devices) have been found at some meth lab sites. Loaded guns and other weapons are usually present and often found in easy-to-reach locations. Code violations and substandard housing structures may also endanger children. They may be shocked or electrocuted by exposed wires or as a result of unsafe electrical equipment or practices. Poor ventilation, sometimes the result of windows sealed or covered with aluminum foil to prevent telltale odors from escaping, increases the possibility of combustion and the dangers of inhaling toxic fumes. Meth homes also often lack heating, cooling, legally provided electricity, running water, or refrigeration. Living and play areas may be infested with rodents and insects, including cockroaches, fleas, ticks, and lice. Individuals responding to some lab sites have found hazardous waste products and rotten food on the ground, used needles and condoms strewn about, and dirty clothes, dishes, and garbage piled on floors and countertops. Toilets and bathtubs may be backed up or unusable, sometimes because the cook has dumped corrosive byproducts into the plumbing. (See *Children Found in Meth Lab Homes*.)

The inability of meth-dependent and meth-manufacturing parents to function as competent caregivers increases the likelihood that a child will be accidentally injured or will ingest drugs and poisonous substances. Baby bottles may be stored among toxic chemicals. Hazardous meth components may be stored in 2-liter soft drink bottles, fruit juice bottles, and pitchers in food preparation areas or the refrigerator. Ashtrays and drug paraphernalia (such as razor blades, syringes, and pipes) are often found scattered within a child's reach, sometimes even in cribs. Infants are found with meth powder on their clothes, bare feet, and toys. The health hazards in meth homes from unhygienic conditions, needle sharing, and unprotected sexual activity may include hepatitis A and C, *E. coli,* syphilis, and HIV.

Social problems. Children developing within the chaos, neglect, and violence of a clandestine methamphetamine laboratory environment experience stress and trauma that significantly affect their overall safety and health, including their behavioral, emotional, and cognitive functioning. They often exhibit low self-esteem, a sense of shame, and poor social skills. Consequences may include emotional and mental health problems, delinquency, teen pregnancy, school absenteeism and failure, isolation, and poor peer relations. Without effective intervention, many will imitate their parents and caretakers when they themselves become adults, engaging in criminal or violent behavior, inappropriate conduct, and alcohol and drug abuse.

> Many children who live in drug homes exhibit an attachment disorder, which occurs when parents or caretakers fail to respond to an infant's basic needs or do so unpredictably. These children typically do not cry or show emotion when separated from their parents. Symptoms of attachment disorder include the inability to trust, form relationships, and adapt. Attachment disorders place children at greater risk for later criminal behavior and substance abuse.
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> http://www.ojp.usdoj.gov/ovc/publications/bulletins/children/pg5.html

Children potentially exposed to methamphetamine, the chemicals used to make it or the byproducts and waste created by it require and deserve immediate and long-term assessments and care if necessary. Statewide multidisciplinary policies and protocols should be established. The SLC recognizes resources vary across the state and a "one size fits all" approach will not work. However, there are certain guidelines and practices that should be followed to protect children potentially and actually exposed to methamphetamine. Action on this recommendation is critical to the protection of children in Tennessee.

The creation of another entity or group is probably not necessary to address this recommendation. The Tennessee Alliance for Drug Endangered Children (TADEC) has already developed templates of protocols to use for children potentially exposed to methamphetamine and other drugs. Approximately 15 counties have developed their own protocols based on the templates.

6. **Reoccurring Finding**: Multiple referrals of child abuse often occur prior to investigation and determination of the first incident of indicated abuse.

   Recommendation: Monitor ongoing efforts of DCS to address the finding.

   Explanation: In response to the finding in last year's SLC report, DCS has initiated pilot programs in three DCS regions to address multiple referral issues. Matters in which a child of a certain maximum age (which currently varies based on the region) receives a third referral, a regional review is initiated. A consultative group of individuals from the region come together to conduct a full history review and provide guidance to the Child Protective Services worker. Among other things, the consultative group addresses immediate safety of all children involved and long-term goals for the matter when appropriate.

7. **Finding**: A statewide child abuse resource directory is needed for stakeholders to help them find expertise in various areas of child abuse prevention, education and services.

   Recommendation: Produce a statewide child abuse resource directory.

Explanation: The purpose of the child abuse resource directory is to provide child abuse prevention stakeholder contact information, expertise and unique information regarding various child abuse resources, and links to additional locations that provide information and resources regarding child abuse. Child abuse prevention stakeholders as well as service providers across the state would benefit from knowing about resources and expertise available to them in their region and throughout the state.

During the course of investigating cases, several of the SLC members from rural counties stated the child abuse prevention stakeholders and service providers in their area would benefit from knowing where additional resources are since many rural areas lack the necessary child abuse prevention and education resources and specialty expertise in various subject matters.

8. **Finding**: A female child remained in a home with a person indicated for sex abuse against her older sister. The older sister (victim) was removed from the home. The remaining female child was not the daughter of the perpetrator.

   Recommendation: DCS, the SLC and other appropriate stakeholders should work together to conduct a policy review to determine whether DCS has sufficient policies in place to reduce the likelihood of a child being placed or remaining in the home of a non-relative indicated perpetrator.

   Explanation: Opinions vary regarding recidivism rates for those who sexually abuse children. Many professionals believe recidivism rates for child molesters are next to impossible to ascertain. One of the main reasons is recidivism rates often only count the number of child sexual abusers who are convicted, released back into the community and are caught and convicted again. Additionally, recidivism rates across studies often vary due to differences in legal guidelines and statutes among states, length of exposure time (i.e., time in the community, where the opportunity exists to reoffend), offender characteristics, treatment-related variables, amount and quality of post-treatment supervision, and many other factors. Regardless of the variances in recidivism rates, the sexual abuse of anyone is an intolerable act.

   The SLC recognizes and agrees with the best practice of maintaining the family unit when appropriate and not needlessly separating children from the people they love. Such practices are guided by state and federal statutes. In fact, the Policy Statement in DCS policy 14.12 clearly states, "The Department of Children's Services shall exhaust all home-based services and options in the effort to alleviate immediate safety issues and address the underlying needs before removing children from their homes. Removal must be the last option available to ensure the child(ren's) safety."

However, DCS policies also place the immediate safety of children first. DCS policy 14.12 also provides reasonable efforts cannot take precedence over the immediate safety of the child. DCS policy 14.12.I. prohibits individuals from being a non-custodial placement if the person has been convicted of certain felonies, including crimes against children and crimes involving violence. Convicted felons not specifically excluded may be placement resources only if they receive a waiver based on various factors. DCS policy 16.4 also prohibits certain felons from being custodial resources parents and provides a waiver process for some felons. Additionally, DCS policy 16.4 notes, "All adult household members or significant others (paramours, fiancés, or partners) that have regular access to the children placed in the home and provide a parental role (child care, transportation, discipline, or other support to children) will need to enroll and complete PATH training at initial approval or moving into the home." DCS policy 16.4.J.14.a. provides, "No applicant will be approved as a resource parent who has been determined to be an indicated perpetrator of child abuse or neglect unless a waiver is granted as outlined in DCS Policy 14.24, Child Protective Services Background Checks." These policies, and many others, are evidence of DCS's desire to protect children by limiting their contact with individuals who have previous actions that could place children at a higher risk of abuse or neglect. However, additional safeguards may be necessary to adequately protect Tennessee's children.

In this particular case, the younger sibling who remained in the home with the indicated perpetrator subsequently made allegations of sexual abuse/exploitation against him. However, the allegations were unfounded. Based on the cases investigated this year, this appears to be an isolated incident. However, one incident of leaving a child in harm's way is one incident too many.

Support of DCS Fiscal Year 2013/2014 Budget Proposal

Last year, the SLC made several findings and preliminary findings regarding needed improvements for DCS staff, including the following:

Finding: DCS frontline staff does not consistently have adequate supervision and guidance.

Finding: DCS frontline employees are not adequately compensated or prepared for the level of expertise required in complicated severe child abuse cases resulting in challenges attracting and retaining qualified staff needed to protect Tennessee children. Innovative and creative ways are needed to recruit, support, inspire and retain the highest quality DCS professionals possible. Options to be considered should include student loan forgiveness and performance-based pay increases.

Finding: Cases where children have been abused and then re-abused may go on for years. Many of the children in cases the SLC examined came in contact with a shifting array of social workers or other professionals over a long period of time. Turnover and lack of continuity can lead to poor communication, missed opportunities and mistakes. Similarly, lack of continuity in the CPS field makes proper supervision and guidance much more difficult. The SLC will explore future recommendations to address this situation.

Finding: Sometimes DCS staff fails to timely enter data into Tennessee Family and Child Tracking System (TFACTS)/TnKids, which could impact the safety of children.

Several components of the DCS 2013/2014 proposed budget addresses these findings. DCS proposed a $378,500 increase to upgrade Child Protective Service Investigation Case Manager positions to add more Case Manager 3 positions. The requested increase was made in an effort to retain qualified employees, thereby reducing turnover. Additionally, if more experienced employees are retained, they can provide guidance to the often less experienced frontline staff. DCS also proposed a $1,955,100 increase to add twenty-nine Child Protective Service Investigation and Assessment Case Manager positions to improve caseloads and responsiveness. Such an increase should allow workers to spend more time on the more difficult cases and complete TFACTS in a more timely manner.

DCS proposed two increases in the 2013/2014 budget not specifically contemplated by the SLC. DCS proposed a $1,330,000 to increase the number of Family Service Worker positions. Similarly, DCS proposed a $1,224,200 increase to add 13 new attorney positions. In general, the SLC supports the DCS 2013/2014 proposed budget increases. If properly managed the increases would likely have a positive impact on addressing severe child abuse cases in Tennessee.

Repeat Child Abuse Data

The number of children who experienced a second or subsequent incident of child abuse for fiscal year 2010-2011 is 675.

The gender composition of the victims of the total population of cases is as follows:

- Female: 66 percent;
- Male: 34 percent.

The racial composition of the victims of the total population of cases is as follows:

- White: 69 percent;
- Black: 21 percent;
- Unable to determine: 9 percent;
- Asian: less than 1 percent.

Incidents of repeat abuse by population of the county are as follows:

- Population 49,999 or less: 37 percent;
- Population 50,000 –299,999: 34percent;
- Population 300,000 or more: 29 percent.

The age range composition of the children at the time of the incidents of abuse are as follows:

- 0-4 years old: 13 percent;
- 5-9 years old: 28 percent;
- 10-13 years old: 35 percent;
- 14-18 years old: 24 percent.

The types of abuse in the total population are as follows:

- Drug Exposure: 24 percent;
- Medical Mal.: 1 percent;
- Neglect: 15 percent;
- Physical Abuse: 15 percent;
- Psychological Abuse: 1 percent;
- Sexual Abuse: 44 percent.

Percentage of times the same perpetrator committed both incidents of abuse: 22 percent.

The accuracy of the information provided in this section of the report is disputed by DCS. However, DCS and the SLC are working together to ensure all data provided in the future is accurate.

Statute Summary

The Tennessee Second Look Commission is charged with reviewing an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the General Assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state. The Commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse.

The Department of Children's Services (DCS) has the statutory obligation to submit to the Commission a table of cases meeting the criteria of the cases set forth in TCA §37-3-803 (severe child abuse). The Commission shall review the table of profiled cases submitted by DCS and submit a list of the cases to DCS after such review, setting out specific cases from the table that the Commission selects to review.

Notwithstanding any provision of law to the contrary, the Commission may access confidential information. Investigatory meetings of the Commission shall not be subject to the open meetings requirement and shall be closed to the public. Any minutes or other confidential information generated during an investigatory meeting shall be sealed from public inspection.

The Commission is administratively attached to the Tennessee Commission on Children and Youth (TCCY), but for all purposes other than administration, is an independent commission. Among other things, TCCY is responsible for providing the Commission members with any relevant information and assisting the Commission in the preparation of reports.

Conclusion

The Tennessee General Assembly should be commended for its proactive stance regarding protecting the children of Tennessee. Violence against children is increasingly recognized as a national crisis. On December 19, 2012, the House of Representatives of the United States passed H.R. 665, "Protect Our Kids Act of 2012," by a vote of 330-77. The act establishes a commission to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect.

By creating the Second Look Commission, the Tennessee General Assembly recognized the need to improve how severe child abuse cases in Tennessee are handled. Through the creation and continuation of the SLC, Tennessee is proactively addressing issues related to severe child abuse.

The SLC has identified several areas of needed improvement in the investigation and disposition of severe child abuse cases in Tennessee. As recommendations are implemented, the SLC will monitor the impact of the changes over time to determine whether such changes are actually improving how severe child abuse cases are handled in Tennessee.

STATE OF TENNESSEE
SECOND LOOK COMMISSION
Andrew Johnson Tower, Ninth Floor
710 James Robertson Parkway
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

MEMBERSHIP
December 28, 2012

Senator Jim Summerville, Co-Chair
TN General Assembly

Carla Aaron, Executive Director
TN Dept of Children's Services
Office of Child Safety

Bonnie Beneke, Executive Director
TN Chapter of Children's Advocacy Centers

Representative Kevin Brooks
TN General Assembly

Brenda Davis
Vice Chairperson, Board of Directors
Williamson County Child Advocacy Center

David Doyle, Esq.
District Public Defender, 18th Judicial District
District Public Defenders Conference

Senator Dolores R. Gresham
TN General Assembly

Donna Hetherington, Lieutenant
Lexington Police Department

David Imhof, East Precinct Commander
Metropolitian Nashville Police Department

Carlton Lewis, Magistrate
Davidson County Juvenile Court

Debra Quarles Mills, M.D.
East Tennessee State University
James H. Guillen College of Medicine
Department of Pediatrics

Randy Nichols
District Attorney General, 6th District
TN District Attorneys General Conference

Mitzi H. Pollard
Private Attorney

Jerri Powell, Special Agent in Charge
Tennessee Bureau of Investigation

David Haines, General Counsel
Administrative Office of the Courts